

From a Medical Student

Thoughts on Physician-Assisted Suicide

ALEX RALPH DEMAC, *San Diego*

We live in a society where the average person is unfamiliar and uncomfortable with death. Beginning with what many psychologists think is an innate block to realizing our own mortality, we go on to shield ourselves in every way possible from the occurrence of death. People die in institutions rather than in the home, and the opportunity to spend time with the dead person at the time of death and perhaps at the funeral home later are quite abbreviated compared to the days-long vigils over the dead of other times and other societies. Our culture emphasizes youth and shuns and ignores the aged, as if to banish from our minds the deterioration and demise for which we all are bound.

Many, if not most, people have never been present at the death of another. Certainly, as we get older and our friends and relatives die, the truth becomes more evident, but we are so conditioned to denial that the truth often is hard indeed to accept.

Into this setting come two organizations: the Hemlock Society and Americans Against Human Suffering. In euphemistic terms they call for "the right to self-deliverance," "voluntary active euthanasia," and "assisted suicide." In the boldest, clearest possible terms, what they seek is legalized mercy killing. The Americans Against Human Suffering organization is gathering signatures for a ballot initiative—the so-called Humane and Dignified Death Act (California Civil Code, Title 10.5*)—that would make physician intervention to cause the death of a consenting, terminally ill patient a legally protected activity in the state of California. If its sponsors are successful, the act will be submitted to the voters in the form of a referendum.

Under the terms of the proposed initiative, any person certified by two physicians as being terminally ill and unlikely to live longer than six months would be entitled, upon the execution of a simple document, with witnesses, to immediate assistance from his or her physician in committing suicide. This would involve anything from writing a prescription for a lethal drug to "any medical procedure that will terminate the life of the qualified patient swiftly, painlessly, and humanely." The physician and any who help in this task would be immune from criminal, civil, or administrative liability. Any physician refusing to assist in the killing would be required to make arrangements for the transfer of the patient's care to another, more willing physician.

In his book, *Let Me Die Before I Wake*, Humphrey makes the case for this legislation simply, poignantly, and persua-

sively.¹ His argument is primarily one for patient autonomy and personal sovereignty. A terminally ill patient, he says, should have the right to choose the time and circumstances of his or her death. The patient should not have to suffer through a mental or physical decline, emotional and/or physical pain, and the additional expense of treatment if he or she does not want to. If there is no hope, why prolong suffering needlessly?

Patients in this position currently face a number of barriers to "self-deliverance." First, their behavior is legally and socially unsanctioned, so they must make their preparations furtively. Second, the most effective drugs for committing suicide are available only by prescription. People are, therefore, forced to go to great lengths to accumulate a lethal hoard of pharmaceuticals, and in many cases may have to use slower, less certain, and less comfortable drugs or choose other methods of suicide. Third, and perhaps most compelling, is the question of what happens to people who are physically or mentally unable to accomplish their own suicides and know no compassionate souls who will risk helping them. Are they to be abandoned to slow, lingering, painful, undignified, and expensive deaths?

In a series of case histories, Humphrey tells the stories of terminally ill people who accomplish suicide with the help of spouses, children, and friends. In each case the person dies happier, the friends and relatives feel good about their participation, and the last hours spent together are filled with a sense of love, serenity, and even triumph. Why not let all people who choose to die in this way do so without hindrance?

The answer to this question has less to do, I think, with how and when we let people die than it does with how and when we let people kill. Certainly, in my opinion, people who make up their minds to kill themselves have the moral right to do so. They may be considered foolish. They may be called inconsiderate to inflict emotional pain on those who value their lives and will mourn their passing. I think that it is their lives, and so long as they are discreet in choosing the time and method of suicide and attentive to the details, they should not have a problem. The real difficulty begins when they want someone to help them.

We live in a polis that rigidly limits the conditions under which one person may kill or help to kill another. Soldiers are allowed to kill enemies during military confrontations. Police and civilians are allowed to kill in self-defense. Certain criminals may be put to death as punishment for their crimes. All of these cases involve people whose lives have been devalued by virtue of their assuming evil roles relative to the commonweal. While a physician is permitted to hasten a patient's

*Copies available from Americans Against Human Suffering, 2506 Cañada Blvd, Suite 2, Glendale, CA 91208.

death by giving morphine, the killing is a by-product of pain relief rather than a stated goal.

The proposed legislation would therefore extend government's role in a significant new direction. It would be given the power and the responsibility to kill the "good guys," people who have not hurt anyone but have devalued their own lives based on their personal views of their lives and circumstances. What are the justifications, limitations, and dangers of such an expansion of power?

The Hemlock Society says that terminally ill people should not have to suffer, but why should anyone have to suffer? Suffering exists and abounds, not simply among the terminally ill. Should anyone who suffers be entitled to help in committing suicide? A possible response is that terminally ill people are unique in that they have no hope. Others have the possibility of relief, of a life after the suffering, but the terminally ill do not. It may, therefore, be argued that there is no reason to force the terminally ill to suffer through as long a period as six months before they finally die and are released.

There are, however, many who suffer great physical pain without hope of relief. For example, the severely handicapped or the severely and chronically ill have to suffer, with no prognosis for improvement. If the terminally ill should not be forced to suffer for six months, why should these people be forced to suffer for years? More to the point, what is the nature of this suffering? Under the proposed initiative, a person would be entitled to assisted death from the moment of being diagnosed as being six months from death, even if no significant deterioration or pain had yet occurred. A terminally ill patient, then, with little physical pain could demand help in committing suicide while a chronically handicapped but not terminally ill person with much more severe pain could not. It is, therefore, impossible to argue that the terminally ill suffer uniquely or are uniquely entitled to a particular form of relief. We must either refuse to grant them assisted suicide on demand or extend the right to others as well.

An important question to ask at this juncture is whether suicide is the only possible solution to the suffering of a terminally ill person. Many believe that it is not. If significant pain does exist, there is no reason why it cannot be palliated by the armamentarium of pain relievers, including morphine and neurosurgery, that are available. If pain is so terrible that death can provide the only relief, it is generally and increasingly recognized that physicians may increase the dosage of morphine until death is in fact effected. This is something the patients can discuss with their physicians in advance, so that they may be assured that they will not suffer unduly.

The Hemlock Society maintains that the terminally ill should not have to suffer the emotional distress and indignity of physical and mental deterioration and increasing dependence on others. Quality of life, however, is entirely subjective, and the hospice movement has shown that even severely debilitated patients can lead meaningful lives. The loss of youth and vitality is eventually suffered by everyone, if they live long enough. As Dyck has pointed out:

If minimizing suffering is linked with killing, we have the unfortunate implication that killing is a quicker, more painless way to alleviate suffering than is the provision of companionship for the lonely and long-term care for those who are either dying or recuperating from illnesses.²

The Hemlock Society further states that terminally ill people should not have to receive pointless, expensive, life-prolonging treatment. This is certainly justified, and as living wills and the right to refuse treatment become institutional-

ized, as they increasingly are, this will not be a problem. Termination of treatment issues, however, should not be confused with termination of life by "assisted suicide."

While it is difficult for me to understand why death by mercy killing is necessary to ease the departure of a terminally ill person, I see a number of dangers inherent in its legalization. First and foremost, it is quite possible that a social and psychological climate would be created under which terminally ill people would be *expected* to exercise this option. A large amount of money, including a major portion of Medicare payments, is now spent on the care of the terminally ill and could instead be used for other things. Governor Richard Lamm of Colorado has spoken of the duty of the elderly to die. It would be easy for this attitude to be spread in the media to the point where it might act as a pressure on the terminally ill to opt for death by mercy killing. Families and physicians caring for the terminally ill might well be tempted to urge this option on a person to save themselves from the strain of such care.

Furthermore, because, as previously discussed, there is nothing qualitatively unique about the suffering of the terminally ill, it is likely that the right to death by mercy killing and the pressure to take that option would soon be extended to all chronically ill, elderly, and handicapped people. In fact, the underlying assumption of The Humane and Dignified Death Act, which is that poor quality of life is a justification for death, would put society on a slippery slope with no bottom in sight. It is easy to envision a time, especially during an economic depression or a war, when resources are scarce and anyone would be entitled to assisted suicide simply because they were dissatisfied with the quality of their lives. During such a time, a "reasonable person" rule might be applied to those not able to make a choice—the insane, the mentally retarded, or handicapped children—who might be put to death without having any say in the matter on the basis of their relatively poor quality of life.

A final question relating to assisted suicide is who should do the assisting. The Humane and Dignified Death Act calls for physicians to assume this role, but should they? Just as physicians do not participate in executions, they need not be involved in mercy killing. There could be certified thanatologists, or euthanasia societies could establish right-to-die clinics. If physicians are the killers, it arguably could effect a great change in their image and role. Certainly, if assisted suicide becomes a treatment option, all physicians will be required to mention it to their patients or be liable for not keeping their patients properly informed. The proposed legislation requires that a physician opposed to killing a patient must find that patient a physician who will. In this way the physician's complicity is coerced, and proper medical conduct is defined by those outside the profession. On the other hand, in this age of commercial medicine, one can readily imagine physicians competing with one another through advertisements on the basis of their euthanasia services. The image of physicians would thus change from being champions of life to angels of death.

The problem with laws is that often they provide a sledgehammer where a feather is needed. It is widely noted that there are instances when physicians have actively helped patients to die. The impulse is to enshrine this practice in law so that any patient may receive such help and no physician need fear a penalty for providing it. The problem is that this would make the practice easier and more commonplace than it

should be and leave society open to the undesirable consequences mentioned.

A more sensible middle ground has been taken in the Netherlands. While they have not legalized physician-assisted suicide, authorities in that country have worked with the Royal Dutch Medical Association to determine criteria under which physicians may be permitted to help terminally ill patients to die. These include the stipulation that euthanasia will be carried out only if there is unbearable suffering that fails all pain-killing efforts. The goal, according to one Dutch practitioner, is to "prevent the deed's arising from mere subjective despair in an exhausted patient or from a doctor's proselytizing" (*The New York Times*, October 31, 1986, p A4). Implicit is that such a decision should be arrived at by a physician and patient in the context of a long-standing and intimate physician-patient relationship. It is not a decision to be arrived at casually or between physicians and patients who

are strangers to one another. Furthermore, cooperation by a physician or other party in such an act should not be coerced in any way.

While suicide in the face of death may be a dramatic assertion of self-determination and the legalization of such practice an affirmation of personal autonomy, we as a society are not ready for such a big step. At this time, we should move forward carefully, allowing the courts, the medical profession, and the public to monitor the situation as we go. The worst thing we could do is to pass a referendum whose provisions would be clumsily broad, and which, by the very nature of referendums, would be difficult to amend as its flaws became apparent.

REFERENCES

1. Humphrey D: *Let Me Die Before I Wake*, 4th Ed. Los Angeles, The National Hemlock Society, 1987
2. Dyck A: Beneficent euthanasia and benemortasia: Alternative views of mercy. In Kohl M (Ed): *Beneficent Euthanasia*. Buffalo, NY, Prometheus Books, 1975, pp 121-122

AIDS in Children

WHAT ABOUT PRECAUTIONS? In the hospital, this is how we deal with things: We put up our sign, which is the same sign that we use for hepatitis B precautions; obviously, it doesn't say anything about AIDS or HIV. It's called "blood and needle precautions": Children with opportunistic infections, children with chronic generalized lymphadenopathy, failure to thrive, who might be in a high-risk group, and children, obviously, with possible AIDS.

In general, we try to group them together or put them in a single room, both in order to keep them away from other patients (so they don't get infected with RSV and all those other things that go around our ward) but also for obvious reasons. Contaminated linen and all specimens should clearly have a biohazard warning.

The precautions that we take are the same as those we use for hepatitis B. We use gloves if we're going to be in contact with secretions or blood. We use gowns, once again, if we're going to be in direct contact with those things.

Surfaces should be decontaminated. The people who tend to use goggles are the gastroenterologists who are doing procedures on these patients. Generally speaking, we don't use either masks or goggles when we're dealing with these children.

Now, what about at home? Probably the most difficult problem that I have is dealing with the child in the first year of its life, when you don't know what's going on. Later on, when you know a child is infected, it's much easier to talk to parents. If I don't know the child is infected, what I say is that if the mother has any problem with her hands, why, I have her get disposable gloves and use those for any diaper change. Clearly, you want to use extreme care with blood. The parents should wear gloves when they're dealing with any cuts and take care to disinfect.

—KENNETH McINTOSH, MD

Extracted from *Audio-Digest Pediatrics*, Vol. 33, No. 18, in the Audio-Digest Foundation's series of tape-recorded programs. For subscription information: 1577 E Chevy Chase Dr, Glendale, CA 91206